# RETROACTIVE MEDICAID APPLICATION

State of Michigan

Department of Human Services

**AUTHORITY:** Federal 42 CFR 435. **COMPLETION:** Voluntary.

**PENALTY:** No medical coverage will be authorized.

Department of Human Services (DHS) will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.

| Grantee Name | | | | | Grantee Client ID |
|---|---|---|---|---|---|
| Case Number | | | | Date | |
| County | District | Section | Unit | Specialist | Other ID (as required) |
| | | | | | |

1. My family has unpaid medical bills for the month(s) of:

| First Month | Month | Year | Second Month | Month | Year | Third Month | Month | Year |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |

▼ ANSWER QUESTIONS 2-9 FOR EACH MONTH APPLIED FOR IN QUESTION 1. ▼

| 2. List yourself and the name of each family member who lived with you at any time during the **first month**. Check yes if the person has unpaid medical expenses this month. | 2. List yourself and the name of each family member who lived with you at any time during the **second month**. Check yes if the person has unpaid medical expenses this month. | 2. List yourself and the name of each family member who lived with you at any time during the **third month**. Check yes if the person has unpaid medical expenses this month. |
|---|---|---|
| ☐ YES | ☐ YES | ☐ YES |
| ☐ YES | ☐ YES | ☐ YES |
| ☐ YES | ☐ YES | ☐ YES |
| ☐ YES | ☐ YES | ☐ YES |
| ☐ YES | ☐ YES | ☐ YES |
| 3. Was a family member(s) in a hospital, nursing home, or away from home on the last day of the **first month**? ☐ YES ☐ NO If YES, enter name of family member(s): | 3. Was a family member(s) in a hospital, nursing home, or away from home on the last day of the **second month**? ☐ YES ☐ NO If YES, enter name of family member(s): | 3. Was a family member(s) in a hospital, nursing home, or away from home on the last day of the **third month**? ☐ YES ☐ NO If YES, enter name of family member(s): |
| | | |
| 4. Explain any changes during the **first month** (child born, family member left or returned home, married, divorced, died, began or ended pregnancy, began or quit work) and indicate date of change. | 4. Explain any changes during the **second month** (child born, family member left or returned home, married, divorced, died, began or ended pregnancy, began or quit work) and indicate date of change. | 4. Explain any changes during the **third month** (child born, family member left or returned home, married, divorced, died, began or ended pregnancy, began or quit work) and indicate date of change. |
| | | |

**INCOME:** (Questions 5-7) For each month applied for, attach proof of all income received. Attach copy of court order(s) for child support paid.

| 5. **Was any family member employed or self-employed in any of the months listed in question 1? ☐ YES ☐ NO If YES, complete the following:** | **FIRST MONTH** | | **SECOND MONTH** | | **THIRD MONTH** | |
|---|---|---|---|---|---|---|
| | Total monthly earned income before deductions | Names of children receiving child care due to employment. | Total monthly earned income before deductions | Names of children receiving child care due to employment. | Total monthly earned income before deductions | Names of children receiving child care due to employment. |
| Person employed: | $ | | $ | | $ | |
| | $ | | $ | | $ | |
| Name of Self-Employed Person | Gross Monthly income, minus allowable federal tax deductions (DEPRECIATION not allowed) | | Gross Monthly income, minus allowable federal tax deductions (DEPRECIATION not allowed) | | Gross Monthly income, minus allowable federal tax deductions (DEPRECIATION not allowed) | |
| | | | | | | |

| 6. **Did any family member pay child support in any of the months listed in question 1? ☐ YES ☐ NO If YES, complete the following:** | Total monthly child support paid | Total monthly child support paid | Total monthly child support paid |
|---|---|---|---|
| Person paying expenses: | $ | $ | $ |

| 7. **Did any family member pay guardianship/ conservator expenses in any of the months listed in question1? ☐ YES ☐ NO If YES, who pays?** | 7. **Did any family member pay guardianship/ conservator expenses in any of the months listed in question1? ☐ YES ☐ NO If YES, who pays?** | 7. **Did any family member pay guardianship/ conservator expenses in any of the months listed in question1? ☐ YES ☐ NO If YES, who pays?** |
|---|---|---|
| | | |

8. **OTHER INCOME**: Include income of all family members. Each item must be answered YES or NO.

| | FIRST MONTH Month Year | | | | SECOND MONTH Month Year | | | | THIRD MONTH Month Year | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **INCOME TYPE** | YES/NO | | MONTHLY AMOUNT | WHOSE INCOME | YES/NO | | MONTHLY AMOUNT | WHOSE INCOME | YES/NO | | MONTHLY AMOUNT | WHOSE INCOME |
| Social Security Benefits (RSDI) | | | $ | | | | $ | | | | $ | |
| Supplemental Security Income (SSI) | | | $ | | | | $ | | | | $ | |
| Retirement or Pension Benefits | | | $ | | | | $ | | | | $ | |
| Veterans Benefits | | | $ | | | | $ | | | | $ | |
| Disability Benefits | | | $ | | | | $ | | | | $ | |
| Rental Income | | | $ | | | | $ | | | | $ | |
| Workers Compensation | | | $ | | | | $ | | | | $ | |
| Child Support or Alimony | | | $ | | | | $ | | | | $ | |
| Unemployment compensation | | | $ | | | | $ | | | | $ | |
| Military Allotments | | | $ | | | | $ | | | | $ | |
| Gambling Distributions (Casino profit sharing) | | | $ | | | | $ | | | | $ | |
| Other | | | $ | | | | $ | | | | $ | |

9. **ASSETS**: Include assets of all family members. Each item must be answered YES or NO. Attach proof of asset value for each retro month applied for.

| | FIRST MONTH Month Year | | | | SECOND MONTH Month Year | | | | THIRD MONTH Month Year | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ASSET TYPE | YES/NO | | AMOUNT/VALUE | OWNER(S) | YES/NO | | AMOUNT/VALUE | OWNER(S) | YES/NO | | AMOUNT/VALUE | OWNER(S) |
| Cash on hand, in a safety deposit box or patient trust fund | | | $ | | | | $ | | | | $ | |
| Savings, Checking or Credit Union Accounts | | | $ | | | | $ | | | | $ | |
| Home, life estate, life lease | | | $ | | | | $ | | | | $ | |
| Real Estate (not your home) | | | $ | | | | $ | | | | $ | |
| Mortgage, land contract or other notes payable to household member | | | $ | | | | $ | | | | $ | |
| Savings bonds or money market funds | | | $ | | | | $ | | | | $ | |
| Stocks or mutual funds | | | $ | | | | $ | | | | $ | |
| IRA, KEOGH, 401K or deferred compensation accounts | | | $ | | | | $ | | | | $ | |
| Trust Fund(s) | | | $ | | | | $ | | | | $ | |
| Life insurance | | | $ | | | | $ | | | | $ | |
| Annuity | | | $ | | | | $ | | | | $ | |
| Cars, trucks, boats, motorcycles, other vehicles | | | $ | | | | $ | | | | $ | |
| Tools & Equipment, Livestock or Crops | | | $ | | | | $ | | | | $ | |
| Funeral contracts | | | $ | | | | $ | | | | $ | |
| Burial plot(s), casket, etc. | | | $ | | | | $ | | | | $ | |
| Certificates of Deposit (C.D.) or savings certificates | | | $ | | | | $ | | | | $ | |
| Other | | | $ | | | | $ | | | | $ | |

**I CERTIFY THAT ALL INFORMATION I HAVE WRITTEN ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE.**

| Signature | Date | Signature of Spouse | Date |
|---|---|---|---|
| | | | |